TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Bitco General Insurance Corp

MFDR Tracking Number
M4-16-1841-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "They denied code E0190 stating that it was not medically necessary."

Amount in Dispute: $99.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "attached is a copy of the carrier's dispute information indicating that the condition for which Claimant is being treated is not related to the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2015	E0190	$99.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out general rules of dispute of medical bills.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – Service not Deemed "Medically Necessary" by payer
   - 193 – Original payment decision maintained
   - B13 – Payment for service may have been previously paid

Issues

1. Is the dispute eligible for medical fee dispute resolution?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 50 – "Service not Deemed not Medically Necessary by payer." Review of the submitted documentation finds that the medical fee dispute referenced for date of service November 23, 2015, contains information/documentation that indicates that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The medical fee dispute for date of service November 23, 2015, may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The Division finds that due to the unresolved medical necessity issues for date of service, November 23, 2015, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered.

   The Division finds that date of service, November 23, 2015, is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.